

Name _____ Referred By _____ Date _____
 Why are you here today? _____

Medical System Review (Please circle and explain any medical problems)

- Constitutional fever, weight loss, fatigue
- Eyes cataracts, sudden change in vision
glaucoma, blurring, pain, double vision
- Ear, Nose, Throat sinus problems, hearing problems,
throat problems
- Cardiovascular chest pain, high blood pressure, heart attack
irregular rhythm, heart surgery
- Respiratory cough, wheezing, shortness of breath, pneumonia
bronchitis, TB, emphysema
- Gastrointestinal ulcers, gall bladder trouble, colitis, blood in stools
diverticulitis, jaundice, liver problems.
- Genitourinary infection, stones, blood in urine, urine leakage
painful urination, difficulty urinating,
frequent urination
- Neurologic tremors, dizziness, numbness, seizures, headache
stroke, black outs, Parkinsons
- Allergic/Immunologic hives, hay fever, asthma
- Endocrine diabetes, thyroid trouble
- Skin rash, sores, itching, burning
- Musculoskeletal back pain, joint pain, arthritis, gout
- Hematologic/Lymphatic easy bruising, swollen glands, prolonged
bleeding
- Psychologic depression, mood swings, anxiety

Marital Status (circle one): married single
widowed divorced

Most recent occupation: _____

Current Medications _____

Current Medical Problems

Check the illnesses that apply to your immediate family (parents, siblings, children)

- _____ Diabetes _____ Heart Disease
- _____ Cancer _____ Kidney Disease
- _____ Arthritis _____ Mental illness
- _____ Tuberculosis _____ High Blood Pressure
- _____ Anemia _____ Stroke

Past Hospitalizations (with dates)

Tobacco (cigarettes, pipe, cigars): How much per day? _____

Caffeine: (cola, tea, coffee) _____

Alcohol (beer, wine, liquor): How much per day? _____

ALLERGIES
